



JUN 20 2002

Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

CIN: A-01-02-00500

Ms. Sally Mason Boemer, Vice President for Finance  
Massachusetts General Hospital  
55 Fruit Street, Bulfinch 380  
Boston, Massachusetts 02114-2696

Dear Ms. Boemer:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Audit of Outlier Payments Made to Massachusetts General Hospital Under the Outpatient Prospective Payment System For the Period August 1, 2000 Through June 30, 2001". If you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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Sincerely yours,

*Michael J. Armstrong*  
Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Associate Regional Administrator for Medicare  
Centers for Medicare & Medicaid Services – Region 1  
U. S. Department of Health and Human Services  
J.F.K. Federal Building – Room 2325  
Boston, Massachusetts 02203

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**AUDIT OF OUTLIER PAYMENTS MADE  
TO MASSACHUSETTS GENERAL  
HOSPITAL UNDER THE OUTPATIENT  
PROSPECTIVE PAYMENT SYSTEM FOR  
THE PERIOD AUGUST 1, 2000 THROUGH  
JUNE 30, 2001**



**JANET REHNQUIST**  
**Inspector General**

**JUNE 2002**  
**A-01-02-00500**

# ***Office of Inspector General***

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## **EXECUTIVE SUMMARY**

### **Background**

The Balanced Budget Act of 1997 mandated that the Centers for Medicare & Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such CMS implemented the outpatient prospective payment system (OPPS). The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of OPPS. One provision requires that CMS make an outlier payment to hospitals to cover some of the additional cost of providing care that exceeds established thresholds. Hospitals are required to submit Medicare claims to the fiscal intermediaries (FI) for billing purposes using standard UB-92 claim forms. Information reported by hospitals on the UB-92 must be correct to ensure proper and timely Medicare reimbursement. Incorrect data, including inaccurate billable units, may cause Medicare claims processing systems to generate unwarranted outlier payments.

### **Objective**

The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations. Our review included outlier payments to Massachusetts General Hospital (MGH) for services rendered during the period August 1, 2000 to June 30, 2001.

### **Results of Review**

We found that a weakness in MGH's billing controls to convert drug dosages to billable units resulted in excessive Medicare outlier payments to the MGH. The MGH officials believe complexities and inconsistencies in the billing guidelines during the OPPS implementation period contributed to problems converting clinical units of the drug intravenous immune globulin (IVIG) to billable units. Based on our review of 30 judgmentally selected outpatient hospital claims with outlier payments totaling \$95,464, we found that for 14 of the 30 claims MGH received overpayments totaling \$9,803 because the hospital billed the incorrect number of units for IVIG. Due to the high risk of incorrectly billed claims that include IVIG, we requested that MGH perform an internal review of all outpatient claims with IVIG for dates of services between August 1, 2000 and December 31, 2001. Based the internal review, the hospital identified additional overpayments totaling \$156,023. We commend the hospital for its efforts to identify additional overpayments and strengthen controls for billing IVIG.

Our review also determined 3 of the 30 sampled claims included charges for unnecessary observation care, resulting in \$2,168 in overpayments to the hospital.

### **Recommendations**

We recommend that MGH: 1) continue to strengthen its billing controls and periodically monitor claims that include IVIG to ensure the services are billed correctly; 2) improve its controls over the billing process to ensure that only medically necessary observation care is billed and; 3) initiate adjustments with its FI to reimburse Medicare for the \$167,994 in overpayments for incorrectly billed IVIG claims (\$165,826) and claims that included medically unnecessary observation care (\$2,168).

### **MGH's Comments**

In its response to our draft report, MGH concurred with our findings and recommendations and noted that adjustments with its fiscal intermediary are virtually complete.

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## **INTRODUCTION**

### **BACKGROUND**

The Balanced Budget Act of 1997 mandated that Centers for Medicare & Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the outpatient prospective payment system (OPPS). With the exception of certain services, payment for services under OPPS is now calculated based on grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. In this respect, some services such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms are packaged in APCs and not paid separately. The OPPS became effective for services provided on or after August 1, 2000.

The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of OPPS. One of the provisions requires that CMS make an outlier payment to hospitals to cover some of the additional cost of providing care that exceeds established thresholds. Outlier payments are determined by: (1) calculating the costs related to the OPPS services on the claim by multiplying the total charges for covered OPPS services by an outpatient cost-to-charge ratio; (2) determining whether these costs exceed 2.5 times the OPPS payments; and (3) if costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent of the amount by which the costs exceed the OPPS payments.

Hospitals are required to submit Medicare claims to the fiscal intermediaries (FI) for billing purposes using the standard UB-92 claim form. Claims information reported by hospitals on the UB-92 needs to be correct to ensure proper and timely Medicare reimbursement. Incorrect data, including inaccurate billable units, may cause Medicare claims processing systems to generate outlier payments that are not warranted.

Massachusetts General Hospital (MGH), located in Boston, Massachusetts, is an 853-bed medical center that admits approximately 37,500 inpatients and handles more than 1.4 million ambulatory and emergency visits each year. The MGH had 8,296 outpatient claims with outlier payments totaling \$5,455,505 for services rendered during the period August 1, 2000 through June 30, 2001.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations. Our review included outlier payments to MGH for services rendered during the period August 1, 2000 to June 30, 2001.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 8,296 outpatient claims with outlier payments totaling \$5,455,505 made to MGH for services rendered during the period August 1, 2000 through June 30, 2001.
- Analyzed MGH's outlier claims for our audit period to identify high risk claims, such as those where the outlier payment represented a significant percentage of the total payment of the claim. On this basis, we selected a judgmental sample of 30 claims with outlier payments totaling \$95,464 for review.

- Held discussions with MGH and Partners Healthcare, Inc. compliance and billing personnel to obtain an understanding of MGH's procedures for accumulating charges, creating outpatient bills, and submitting Medicare claims.
- Utilized medical review staff from the FI, Associated Hospital Service (AHS), to determine the medical necessity for the services for selected claims.

We limited consideration of the internal control structure to those controls concerning the accumulation of charges, the creation of outpatient bills, and submission of Medicare claims. The objective of our review did not require an understanding or assessment of the complete internal control structure at the hospital.

We conducted our audit during the period of October 2001 through April 2002 at the MGH in Boston, Massachusetts, the FI in Quincy, Massachusetts and the Boston Regional Office of the Office of Inspector General (OIG). On May 15, 2002, we provided MGH with a copy of our draft report. Their written comments are included as an appendix to this report.

## **FINDINGS AND RECOMMENDATIONS**

We found that a weakness in MGH's billing controls to correctly convert drug dosages to billable units resulted in excessive Medicare outlier payments to the hospital. Based on our review of a judgmentally selected sample of 30 outpatient hospital claims with outlier payments totaling \$95,464, we found that for 14 of the 30 claims MGH received overpayments totaling \$9,803 because the hospital billed the incorrect number of units for the drug intravenous immune globulin (IVIG). Due to the high risk of incorrectly billed claims that include the drug IVIG, we requested that MGH perform an internal review of all outpatient claims with IVIG for dates of services between August 1, 2000 and December 31, 2001. Based on its internal review, the hospital identified additional overpayments totaling \$156,023.

Our review also identified 3 of the 30 sampled claims included charges for unnecessary observation care, resulting in \$2,168 in overpayments to the hospital.

### **INCORRECTLY BILLED IVIG CLAIMS**

For 14 of the 30 sampled claims, we found that MGH received excessive outlier payments because it incorrectly billed the number of units for the drug IVIG. For all 14 claims that included IVIG, the hospital under billed the number of units of IVIG provided to the beneficiaries because it incorrectly converted drug dosages into billable units. As a result, the hospital received lower APC payments than it was entitled to receive for the amount of the drugs actually provided to the beneficiaries. However, the amount of charges billed by the hospital was appropriate for the amount of IVIG administered as documented in the beneficiaries' medical records. Because the calculation of an outlier payment for OPPS claims is contingent, in part, on the total APC payments for the units billed, understated units could result in excessive outlier payments. As a result of the incorrectly billed claims that reduced APC payments and generated outlier payments, MGH received overpayments of \$9,803 for the 14 claims.

With respect to drugs and biologicals, Medicare requires providers to bill the number of units that reflects the actual dosage of the drug furnished to the patient. The following example illustrates the effect on the APC and outlier reimbursement due to under billing the number of units of IVIG:

## ***IMPACT OF UNDERBILLING THE NUMBER OF UNITS OF IVIG***

- For 1 claim, MGH billed for 6 units of the drug IVIG. For Medicare reimbursement, the administration of a 3,000 milligram dosage of IVIG is equivalent to 6 billable units. The hospital charges for this claim, however, were based on the administration of 30,000 milligrams of IVIG. Our review of the medical records substantiated that 30,000 milligrams were provided to the beneficiary. Accordingly, the hospital should have billed for 60 units to properly convert 30,000 milligrams of the drug to billable units. As a result of under billing the number of units, the hospital received an APC payment of \$253.10 for 6 units of the drug and its infusion, instead of the correct APC payment of \$2,654.42 for 60 units of the drug and its infusion. As shown in the calculation below, the correct billing of 60 units results in a considerably higher APC payment and, as a result, eliminates the outlier payment.

<b>OPPS OUTLIER CALCULATION</b>		<b>With 6 units</b>	<b>With 60 units</b>
Total Charges for all OPPS Services:		\$11,197.60	\$ 11,197.60
OPPS Cost to Charge Ratio		0.39965609	0.39965609
Adjusted Costs of OPPS Services		\$ 4,475.19	\$ 4,475.19
Total APC Payments:		<b>\$ 253.10</b>	<b>\$ 2,654.42</b>
2.5 times the APC payments		\$ 632.75	\$ 6,636.05
(Adjusted Cost) Less (2.5 x APC Payment)		\$ 3,842.44	\$ (2,160.86)
Outlier Payment (75% of the difference)		\$ 2,881.83	N/A
<b>REIMBURSEMENT CALCULATION</b>			
APC Payment		<b>\$ 253.10</b>	<b>\$ 2,654.42</b>
Coinsurance		\$ -65.73	\$ -375.15
Outlier Payment		\$ 2,881.83	\$ N/A
<b>TOTAL PROVIDER REIMB</b>		<b>\$ 3,069.20</b>	<b>\$ 2,279.27</b>
		<b>Difference</b>	<b>\$ 789.93</b>

Because payments for OPPS outliers are based on a comparison of the charges for OPPS services to the total APC payments for the claim, the incorrect billing of units results in insufficient APC payments and excessive or unnecessary outlier payments. As shown above, the incorrect billing of 6 units, rather than 60 units, of the drug IVIG for this claim results in an overpayment of \$789.93 to the hospital.

In all claims with IVIG, the number of units billed was understated. The MGH officials believe complexities and inconsistencies in the billing guidelines during the OPPS implementation period contributed to problems converting clinical units of the IVIG to billable units. In this regard, the MGH explained that three different procedure codes were published in the Federal Register and then later clarified on two different occasions, ultimately resulting in a final clarification that limited appropriate reporting of IVIG to only one procedure code. Furthermore, MGH states the payment methodology for IVIG is in conflict with the way the IVIG is packaged and administered.

### **MGH Internal Review of IVIG Claims**

Our analysis of claims data showed there were an additional 164 claims that included the drug IVIG. Due to the high risk of incorrectly billed claims, we requested the MGH to perform an internal review of all claims resulting in payments for IVIG during the period August 1, 2000 through December 31, 2001. The MGH identified additional claims where a combination of using the incorrect IVIG procedure code and under billing the units resulted in underpayments. For these claims, the MGH received an APC underpayment and no outlier payment due to the number of units billed. Overall,



MGH's analysis identified net overpayments totaling \$165,826, including the overpayments totaling \$9,803 for the 14 claims identified by the OIG. The MGH agreed to initiate individual adjustments, through its FI, on all claims for IVIG with billing inaccuracies. In addition, the MGH implemented clinical and billing system changes effective January 1, 2002 to ensure that the appropriate procedure code is used and the correct number of units is billed. We acknowledge the hospital's efforts to identify additional overpayments and strengthen controls for billing IVIG.

## **MEDICALLY UNNECESSARY OBSERVATION CARE**

Our review of the medical records showed that 3 of the 30 sampled claims included charges for excessive hours of observation care. We forwarded these cases to the FI for its determination. The FI's medical review of the claims found \$7,325 in charges for medically unnecessary observation care. As a result, MGH received overpayments of \$2,168. The FI has issued policies specific to outpatient observation care services. In this respect, observation care services that are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, their family, or a physician, are not covered by Medicare. In order for observation care to be allowable there must be a complication or a problem present to warrant the observation care, with the possibility of admitting the patient to the hospital if the problem persists. For these 3 claims the FI found that MGH was billing for observation care for the convenience of either the physician or the patient.

*Section 1862 of the Social Security Act excludes from Medicare items and services which are not medically necessary and reasonable.*

The MGH contends that the observation care was medically necessary for the 3 outpatient claims. However, the MGH believes that there may not have been sufficient documentation in the beneficiaries' medical records to allow the medical reviewer to make an informed determination. Based on our further discussions with the FI, we believe that there is adequate documentation in the patients' medical records to indicate that the observation care was not medically necessary.

## **RECOMMENDATIONS**

We recommend that MGH:

- Continue to strengthen its billing controls and periodically monitor claims that include IVIG to ensure the services are billed correctly.
- Improve its controls over the billing process to ensure that only medically necessary observation care is billed.
- Initiate adjustments with its FI to reimburse Medicare for the \$167,994 in overpayments for incorrectly billed IVIG claims (\$165,826) and claims that included medically unnecessary observation care (\$2,168).

## **MGH's Response to Draft Report**

The MGH agreed with our findings and recommendations. The full text of the hospital's comments are included as the APPENDIX to this report.

## **APPENDIX**



MASSACHUSETTS  
GENERAL HOSPITAL

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**Sally Mason Boemer**  
*Vice President for Finance*

June 4, 2002

Michael J. Armstrong  
JFK Federal Building – Room 2425  
Boston, MA 02203

CIN: A-01-02 – 00500

Dear Mr. Armstrong:

I am writing in response to your office's draft report on review of outpatient outlier payments. We are in agreement with the findings discussed in the report and have moved promptly to respond to recommendations.

- (1) Charge capture and billing systems involving IVIG claims were corrected earlier this year when they were brought to our attention during the audit process.
- (2) A recent internal sample of IVIG claims demonstrated that these systems changes demonstrate correct unit submissions and subsequent correct billing. This sample was conducted in April, 2002. Periodic monitoring will continue in the future.
- (3) We continue to direct close attention to the proper identification of medically necessary observation care and to assist clinicians in understanding appropriate documentation. As staff acknowledged during this audit, the application of these rules is often confusing and we expect will require continued education and monitoring. We are committed to focus on that task.
- (4) Adjustments with our fiscal intermediary are virtually complete (a few claims resubmitted but awaiting confirmation) resulting in agreed upon repayment to the Medicare program.

The hospital would like to acknowledge the cooperation and assistance of your staff in working with us to understand these issues. The outpatient payment system brings with it considerable challenge in implementation. Although our efforts have been directed towards making all necessary system adjustments to our information systems and operational processes, it is a complex task and has resulted in considerable work over a short period of time.

Please contact me should you have any questions concerning this response or the hospital's actions.

Sincerely,

Sally Mason Boemer